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Research and Theory

Motivation to take part in integrated care—an assessment of follow-up home visits to elderly persons

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Abstract

Objectives: The aim of follow-up visits by the general practitioner and district nurse (within a week after discharge from hospital) is to reduce hospital readmissions and improve the overall wellbeing of the patient. There is strong evidence that these programmes are effective, but are difficult to implement because of a number of organizational obstacles, including co-ordination between the organizations involved in the process. In this paper we look at the factors that affect motivation to participate in a cross-sectoral programme in Copenhagen, Denmark, implementing follow-up home visits to elderly persons.

Theory and methods: The analysis is based on inter-organizational network theory in an attempt to explain the role of motivation in network formation between organizational systems. The empirical findings are based on focus groups and in-depth interviews with hospital staff, general practitioners, and district nurses.

Results: Care providers are motivated to collaborate by a number of factors. The focus of collaboration needs to be clearly defined and agreed upon, there needs to be a high degree of equality between the professionals involved, and there has to be a will to co-operate based on a shared understanding of values and learning potentials.

Conclusions: The study concludes that we need to focus on specific care fields and actors to reduce complexity in the area and more fully understand what motivates care providers to participate in cross-sectoral activities, such as a follow-up home visit programme. One lesson for current policy is that motivational factors need to be addressed in future collaborative programmes in order to fully exploit the potential health benefits.

Keywords

collaboration, follow-up home visits, motivation

Introduction

Inadequate organization has been identified as an important cause of inappropriate courses of treatment for patients in the health care system [1, 2]. A response to this challenge has been to focus on integrated health care and co-ordination between the actors involved in the process [3–7]. An illustrative example of this can be found when looking at frail elderly patients on their discharge from hospital. Studies show that readmission can be diminished by increased collaboration between hospital, district nurses and general practitioners [8, 9].

Follow-up home visits by the district nurse and general practitioner to frail elderly patients after discharge have shown promising results [10, 11]. The aim of follow-up home visits to elderly and frail persons is to enable them to remain in their own home, avoid readmission to hospital, admission to nursing homes or other forms of sheltered housing and to improve the functional ability and general wellbeing of the elderly. A follow-up home visit comprises a home visit by a general practitioner (GP) and district nurse within about one week after discharge from hospital. The visit is expected to last approximately one hour, a relatively long period compared to other types of doctor-patient contact. This visit can be supplemented with two subsequent home visits or visits to the GP if this is considered necessary. These visits should be made some three and eight weeks after discharge.

The effect of follow-up home visits on readmissions is significant. The latest study from Denmark has shown that the readmission rate in the intervention group was 40% while it was 53% in the control group [12]. At the same time, studies have shown that there are indications that patients prefer primary care follow-up to specialist care [11]. These results are overall convincing and, as a result, on-going work is being done by health authorities to test and further develop follow-up home visits as an initiative, including a programme in Copenhagen carried out from 2008–2011.

The Copenhagen programme was conducted as a randomized controlled trial which implies strict procedures for the implementation process. A total of approximately 300 patients from Bispebjerg Hospital (a major hospital in Copenhagen) were included in the intervention and control group. Approximately 100 follow-up home visits to patients in the intervention group have been made. In the remaining approximately 200 cases in the intervention group it has not been possible to carry out a follow-up home visit, first of all because GPs could not meet the requirements. In this feasibility study GPs were not carefully selected for the programme as they were in an earlier study [12], and, as a result, more GPs chose not to take part in the programme. The effect of the Copenhagen programme will be reported in 2012 by the Danish Institute of Health Services Research.

This paper will focus on the implementation of follow-up home visits using a qualitative methodological approach. Qualitative studies can help us illuminate the *process* involved when implementing health care programmes [13]. We know some of the general dynamics in the area [7] but we do not know more precisely what the practical limitations of the home visitor's programmes are and how these limitations could make a difference to the outcomes assessed [14, 15]. Why do so few GPs take part in the follow-up home visit programme? Why is the documented effect of such visits not motivation enough for GPs to encourage them to do so? Addressing such questions could help us understand how to design and implement these visits in order to fully exploit the potential benefits of the intervention. Moreover, such results could generate useful hypotheses which could be addressed in future trials attempting to examine the effects of home visiting programmes.

The aim of this study is to explore one particular aspect of follow-up home visits: the motivation and rationale of local care providers to invest time and effort in follow-up home visits. What is the main motivation of GPs, district nurses and hospital staff to take part in a cross-sectoral activity like follow-up home visits?

The case study is placed in a Danish setting. In order to understand the organizational dynamics involved a short description of the setting is needed: the Danish health care system is mainly a public system based on general taxation, and characterized by universal access to health care services. GPs have a central position in the system since they have a kind of 'gatekeeper' function, they are usually the first professional confronted with the patient's problems and they see it as their responsibility to guide patients through the system. GPs are self-employed, general practices are small and typically privately owned; only a minority of GPs are organized in health centres. Home care organizations (district nurses) have occupied an ever more central role since a major administrative reform in 2007 gave the local level the main responsibility for preventive health care [6]. Co-ordination between organizational units in primary and secondary health care is determined by agreements between regional and municipality authorities, which include procedures for such cases as when frail and elderly people are discharged from hospital. Follow-up home visits are not regulated in this agreement.

In general, the Danish system is considered quite integrated, in particular because the climate of trust in Denmark makes co-operation possible [7, 16]. As

a result, follow-up home visits and other cross-sector interventions, such as 'follow-home arrangements' and 'case managers' have been quite regularly implemented on an experimental basis as a possible alternative to hospital-based measures. The interventions have shown promising results but studies in the area also point to problems in connection with implementing the interventions [7, 8, 10, 12, 17, 18].

Theoretical framework

The study was inductive in nature. Empirical data were gathered to develop hypotheses and theoretical concepts. At the same time, however, a rough theoretical framework was used as an underlying foundation in the study to ensure that a relevant focus and approach were applied.

Resource dependency theory tells us that network formation can largely be explained by an organization's need to reduce costs or gain resources and power [19]. Organizations only work together when administrative and economic structures are designed which makes co-operation a profitable pursuit. Organizations thus typically follow their own agenda rather than involve themselves in cross-sectoral activities [20]. In the health sector some support can be found for this basic claim. Studies have shown that network formation in general is limited and poor co-ordination predominant in the area [13, 21].

Resource dependency theory also tells us, however, that organizations need to reduce uncertainty. To reduce uncertainty, organisations tend to co-operate with organisations they trust and depend on to achieve common goals [19, 22]. Hence, in order to understand co-operation you also need to look at the question of trust and the quality of inter-organizational networks, as done in inter-organizational network theory [16]. This perspective has shown us that we need to have a comprehensive view of the factors which make health sector organisations work together. Cross-sectoral programmes and inter-organizational activities are not based purely on partners' own needs and resources [23, 24].

Motivation plays a key role in inter-organizational theory [22, 25]. Working together is a challenging task; it is typically regarded as uncertain whether it will bring benefits equivalent to the resources invested. Motivation and commitment to the process are therefore needed among the actors involved in order to keep things moving and overcome the uncertainties inherent in the process.

What motivates organizations to work together? The literature points to two aspects in particular: the object needs to be seen as highly relevant and benefits should be obvious for all involved [22, 25]. Such general findings have also been found in the health sector [21].

Methodology

This paper is based on an evaluation report made by one of the authors for Health and Social Care, City of Copenhagen [17]. Further documentation of the study can be found in the evaluation report.

The interviews were structured around the following questions:

- To which extent do the actors in the programme regard the content of and target group for follow-up home visits as relevant?
- How do the actors in the programme view communication and workflow in relation to a successful implementation of follow-up home visits? Are the benefits obvious?

In total, two focus groups and seven individual interviews were conducted in March–May 2010, giving a total of 23 respondents.

The focus group approach was chosen because the interaction between some of the key respondents (hospital staff, district nurses) was considered to be of importance, since a key goal in the study was to understand the shared views on collaboration among these key actors in the programme. One focus group interview was conducted with seven employees at Bispebjerg Hospital who were involved in the follow-up home visit programme. Recruitment criteria were designed in order to include a suitable spread of respondents, i.e. to ensure that members of all staff groups directly involved in the project were represented. We ensured that the project co-ordinator at the hospital responsible for the selection of patients for the programme was represented in the focus group. At the same time we also ensured that a doctor and nurses from the most relevant wards were represented. Another focus group interview was conducted with nine district nurses who had been involved in the project. Nurses from different districts in Copenhagen were selected for the focus group in order to ensure that different ways of organising follow-up home visits were represented.

GPs were not as motivated to take part in the research project as district nurses and hospital staff, so a less time-consuming method than focus groups was considered appropriate. As it turned out, in-depth interviews proved to be highly relevant for GPs because GPs had divergent and less firm views about follow-up home visits than other groups in the study and the methodological design allowed these views to be fully expressed.

Five individual interviews were held with GPs involved in the project. Both GPs with a positive attitude towards follow-up home visits and GPs with a less positive attitude were recruited to ensure that a wide range of attitudes was included in the study. These recruitment criteria were based on data registered by the City of Copenhagen showing which GPs had refused to participate in follow-up home visits and which had agreed. At the same time we ensured that the GPs represented covered different districts in Copenhagen.

Two individual interviews were held with employees from referrals in the City of Copenhagen home nursing services. There is a purchaser-provider split in the City of Copenhagen, and the referrals purchase while the district nurses provides. The two referrals came from different districts and had different positions in the organization, ensuring that the most important experiences from this organization were covered.

The focus group interviews took place in a neutral meeting room arranged by the project manager, and the in-depth interviews took place in the GPs' offices. The focus group interviews lasted between 90 and 120 minutes, and the in-depth interviews between 25 and 60 minutes. Both were recorded with a digital voice recorder and transcribed verbatim.

The interview transcripts were analyzed under the two headings which form the basic empirical questions in the study: relevance of collaboration and benefits of collaboration. Quotes from the interviews were grouped under each heading in order to find the quotes which were most illustrative of the views of GPs, district nurses and hospital staff. To ensure reliability, results were presented and discussed in a steering group with representatives from the main professional groups involved in the programme (GPs, district nurses and hospital staff).

Results

Relevance of collaboration

A guide suggesting the ideal content of a follow-up home visit has been designed as part of the programme. GPs and district nurses have been instructed to follow this guide in order to ensure that the same standards and procedures are used in the programme but ultimately it is an individual judgment on the part of the GP and district nurse to decide whether all elements in the guide are relevant in each specific case. The main elements of the guide are: a medication review, a general health assessment (including a number of relevant tests), and an assessment of the need for follow-up arrangements (home care, rehabilitation etc.).

The GPs generally see the follow-up home visit as a relevant type of contact. A GP said: "It is very relevant to make home visits because many elderly patients find it very difficult to go to their GP. They are often very frail when they leave hospital. On top of that, it can give the patient extra resources when you visit the patient on the patient's home ground". The district nurses also generally see the follow-up home visits as a relevant type of contact. A district nurse said: "It very much resembles what we normally do. First, we make observations at the patient's home. Then we communicate with the doctor. It makes a lot of sense".

The GPs find that the medication review is an especially important element in follow-up home visits. A GP said: "We should be able to see what type of medication the patient has. But the patient may have been given some additional medicine by the hospital that we are not aware of, and in this case a home visit is a good way of finding out whether there is a problem with the different types of medicine the patient takes". At the same time the GPs also stress that follow-up home visits are not only about reviewing medication: "The purpose of a follow-up home visit is first of all about making a patient review. It is not only the medicine we should look at, but the patient … In this sense follow-up home visits are very relevant". The district nurses also found that the follow-up home visit was a good way of assessing the health situation of the patient: "The guide creates a good structure for the home visit. If you follow the guide it gives you a good picture of the patient. The doctor and the district nurse can on the basis of the home visit agree what their respective responsibilities are". The two subsequent visits/contacts recommended in the programme are only seldom carried out with the participation of the GP. As a result, the relationship between the GP, the district nurse and the patient is typically not further developed after the first home visit.

At the hospital the general view was also that the content of the follow-up home visit was relevant. At the same time, however, several respondents expressed the need for co-ordination between the hospital and the prime sector: "The guide is quite voluminous. We have already made a lot of the tests at the hospital so there is no need to repeat these at home. You should make sure that the GP has read the discharge summary before the follow-up home visit" (nurse, Bispebjerg Hospital).

The target group of the programme is elderly and frail patients just out of from hospital. A number of specific criteria have been formulated: the patient has to be 65 years or older, been in specific wards at Bispebjerg Hospital, have returned to his or her own home, have experienced deteriorating health, have a limited social network, and experienced many readmissions. At the

hospital the general view was that this patient group is very relevant for the programme. A nurse at the hospital expressed it this way: "It is typically this type of patient that we see again and again: deteriorating health and a small social network". The GPs and district nurses also found that the patient group was very relevant even if they did not find that the use of strict inclusion criteria was the best way to find the most relevant patients. A district nurse stated: "We had a patient where we could not make any difference. Other patients would have benefited from a follow-up home visit but they were not included in the programme".

Benefits from collaboration

GPs receive discharge letters and medicine lists from the hospital when one of their patients is discharged, ideally within three days. This form of communication works fine but is, according to GPs and district nurses in the study, not sufficient when it comes to elderly and frail patients: "It would be natural if the doctor at the hospital contacted the GP directly before the patient is discharged. A follow-up home visit could be agreed and the confirmation of the home visit could be sent to the GP along with discharge letters etc." (district nurse). A GP said: "The hospital has contact with the patient at the time of discharge. It seems obvious that the hospital could phone us and discuss follow-up arrangements. Then it is settled".

In the present situation there is not much direct communication between the hospital and the GP after the discharge of a patient in the target group. It is mainly if there are questions about medicine lists that the GP contacts the hospital and that is not without problems: "If something is missing from the medicine lists or if the district nurse says that the new medicine list from the hospital is different from the old one you need to contact the hospital. But it is often difficult to find out who is responsible and it is difficult to sort out the problem" (GP). The problem, according to several respondents, is that nobody is in charge of this transition phase and, as a result, communication problems occur: "We need an anchor with overall responsibility for the patient when the patient is discharged from hospital. A fax from the hospital to the home nursing services is not enough" (doctor, hospital).

In the city of Copenhagen the home nursing services are responsible for organizing follow-up home visits after the hospital has selected patients which fit the target group and discharged them. It is quite new for district nurses to have this kind of responsibility but according to district nurses it is a responsibility they enjoy having: "Follow-up home visits are all about the patient leaving hospital earlier and about home nurses meeting the patient earlier on and having more responsibility".

The study showed that there was some frustration among GPs because they in many cases were not given full information about the patient by the hospital and the home nursing services and, as a result, they could not be very outreaching. A GP said: "Earlier on I felt more in control. Today I find we often do not hear what is going on in the daily life of our patients. The district nurses know more what is going on than we do". The Health and Social Care administration of the City of Copenhagen has sent pamphlets to GPs informing them about follow-up home visits, and other forms of information have also been used. These activities were set up to inform GPs about the reason for follow-up home visits and to motivate GPs to take part in them. Such information is essential since follow-up home visits are new to many GPs. The study indicated that many GPs react negatively when contacted by the district nurses and that motivation to take part in follow-up home visits was low: "I have experienced very negative-minded doctors when calling to arrange a follow-up home visit. In these cases I received a reprimand and was told that it was certainly not his [the GP's] duty to participate in such a visit" (district nurse).

The GPs who were favourably inclined towards follow-up home visits especially valued that communication between GPs and district nurses was strengthened. A GP said: "You get to talk—that is the biggest gain, to get the dialogue. We work in two parallel organizational systems. By not having the dialogue we as GPs miss some observations. District nurses have another focus and see different things". The GPs want, however, more information about the efficacy of follow-up home visits. GPs in the study find it highly motivating to receive such information if results show an effect on readmission and general health: "If research clearly shows that follow-up home visits have a positive effect it would really give us a moral incentive to participate in these visits. Information could be better" (GP).

At the hospital the staff involved in the programme is very positive towards follow-up home visits. A nurse at the hospital said: "Follow-up home visits are especially important in the case of patients where it has not been possible to offer the most appropriate treatment. It is really nice to know that there is this form of support when patients get home". Communication about the implementation and results of follow-up home visits could, however, be better according to hospital staff. Doctors and nurses at the hospital miss feedback from the follow-up home visits, as illustrated in the following quote: "At meetings we have often asked for the 'good story'. It would make it much more meaningful for us if we were told that Mrs. Jensen is doing really well. That

is the most annoying—that we are not told what the results of follow-up home visits are" (nurse, hospital).

Discussion

The analysis illustrates that it is a big challenge to co-ordinate activities across organizational boundaries and motivate actors to participate in cross-sectoral health programmes. Resources clearly matter (fees for GPs etc.) but the paper also points to other key factors which need to be taken into consideration when trying to motivate partners to engage actively in a cross-sectoral programme like a follow-up home visit programme. In the following these key factors will be discussed under three sub-headings: the focus of collaboration, a partnership of equals, and the will to co-operate.

The focus of collaboration

The analysis indicated that it is beneficial to have agreed upon a common structure for follow-up home visits. The guide specifying the ideal content of these visits ensures that common standards and procedures focusing on the patient's overall situation are followed by all professionals involved. As a result, GPs and district nurses do not follow their usual agendas but are forced to focus on these commonly agreed standards, a type of procedure unusual for the health sector. Collaboration requires partners to subscribe to common standards [22], and the fixed structure of follow-up home visits is a powerful way of defining these standards.

The medication review is a very illustrative example of how GPs and district nurses can work closely together and achieve a shared understanding of the patient's intake of medicine. The study indicates that the GP gains a very realistic picture of the patient's medicine intake during the home visit, a picture the GP could not as easily have gained in a different setting. As a result, communication between the GP and the district nurse about a patient's medicine is typically improved in the treatment following the visit. This is very motivating for GPs and district nurses because communication about changes in medication has been a long-standing problem in Danish health care [6, 23].

The results also showed that follow-up home visits aimed at the right target group, and this motivated care providers to take part in the intervention. Studies have shown that frail elderly patients benefit significantly from follow-up home visits and other types of home visits [17], and that is a notion shared by most GPs and district nurses in the program.

Thus, the results indicate that the object at the centre of these efforts—*the focus of collaboration*—needs to be clearly defined and agreed upon if the actors involved are to be motivated to invest in an extra-ordinary and cross-sectoral activity like follow-up home visits. Inter-organizational studies in the area generally support such a conclusion but also point out that it is a difficult task [18, 26, 27]. Providers in the health sector typically have different incentives, different organizational cultures and working practices and that makes it difficult for them to reach an agreement regarding the focus of their collaborative efforts [26].

A partnership of equals

District nurses have a central role in follow-up home visits. They are responsible for contacting the GP, organizing the visit, and co-ordinating the activities following the visit. The results of the study indicate that district nurses are highly motivated and view these visits as part of a dominant trend in health care, a trend putting more emphasis on primary sector treatment which has evolved as a response to a growing pressure on health services to provide cheaper care than traditional hospital care [6, 8]. This is not surprising since district nurses generally are very positive towards this kind of nurse-led follow-up care and studies have shown that they produce positive results [11].

GPs generally did not feel they had a central role in follow-up home visits and, as a result, felt no responsibility for them. Moreover, follow-up home visits break with GPs' normal routine because they need to leave their practice and they need to co-ordinate their calendar with a district nurse. This is time-consuming and, from a narrow cost-benefit analysis, probably not as rewarding as other activities in general practice. As a result, a programme like the follow-up home visit programme needs to be specific and out-reaching to motivate GPs to take part.

Hospital staff is responsible for selecting patients who need a follow-up home visit after leaving hospital but, despite this essential role, they do not see how they contribute to the overall goals of the programme. The interviews showed that hospital staff lacks information about the actual visits, and how this type of intervention fits into the treatment given at the hospital. Furthermore, hospital staff express a need for more direct communication with the GP. The main argument for this is that the GP would be more fully informed about the treatment of the patient at the hospital and follow-up home visits could, as a result, focus more explicitly on what is most needed. This form of communication between the hospital and GPs could give both hospital staff and GPs a greater sense of responsibility

for follow-up home visits and, as a result, increase the motivation to make these visits. Similar effects have been shown in other studies [8].

It is important for all providers to have an essential role in follow-up home visits and feel a sense of responsibility in order to feel motivated. If the specific roles and responsibilities of the partners are not clear people feel frustrated and motivation suffers [28]. There needs to be a shared responsibility—*a partnership of equals*—to engage all partners in a cross-sectoral activity like follow-up home visits. Research has shown that an interorganizational relationship is at its most effective when it is in equilibrium, a state in which the organizational network is balanced in terms of roles and functions [22, 29]. Research has also shown, however, that there typically are asymmetrical power relations and it is impossible for all members to participate as equals in collaborative processes [30]. For GPs in particular the partnership of equals in follow-up home visits is clearly not equal enough. They are trained to have the prime responsibility for their patients in primary care and find the current state of affairs demotivating [5].

The will to co-operate

The interviews showed that it is important that all partners can see the benefits of working together and understand how they can contribute to achieve shared goals. What is the value and what are the effects of collaborating? GPs in particular need to be convinced that an intervention like follow-up home visits can add something extra to their normal practice. Danish GPs are influenced by a culture of individualism since they are typically small and privately owned entities with few rules and procedures as in larger organizational units, like health centres [18], and it typically requires an extra effort to motivate GPs to take part in a larger scheme, like a follow-up home visit programme.

The results from the study showed that hospital staff also has problems in seeing how they get extra value out of working in partnership. Hospital staff is given no feedback after follow-up home visits, and need a clearer notion of how this type of intervention fits into the treatment given at the hospital. As hospital stays are shortened and follow-up care in the primary health sector is given a larger role in the treatment of elderly and frail patients in particular, the need in the secondary health sector for information about the treatment given in the primary sector is growing [4]. District nurses do not need this type of information to the same extent because they follow the patients more closely and have a clearer notion than GPs and hospital staff of the impact of follow-up home visits.

In order to create more *will to co-operate* regarding follow-up home visits it seems necessary for partners to have a shared understanding of common goals and values, a recommendation also found in other inter-organizational studies in the area [20, 26, 31]. Basically, the partners in the Danish follow-up home visit programme share the understanding that health services need to be more efficient and more coherent. In particular there is a common understanding that the complex needs of frail elderly patients are not adequately dealt with by traditional health care services and require an extra-ordinary and cross-sectoral approach. Follow-up home visits could be the answer to this challenge and the programme could benefit from the basic goodwill among collaborative partners but communication has been insufficient. In particular, there has been a lack of opportunity and incentives for collaborative partners to learn by working together. The learning potentials in integrated care for older people are big, and health care professionals are generally motivated to take part if the learning potential of the experience is clearly communicated [21].

Conclusions

The findings support a basic claim in inter-organizational theory that other factors than resources matter if we want to understand what drives efforts at collaboration. This analysis shows that the focus of collaboration needs to be clearly defined and agreed upon, there needs to be a high degree of equality between the professionals involved, and there has to be a will to co-operate based on a shared understanding of values and learning potentials.

One lesson for current policy is that motivational factors need to be addressed in future collaborative programmes in order to fully exploit the potential health benefits. The follow-up home visit programme in Copenhagen suffered from a lack of motivation among key actors (especially GPs) to participate and, as a result, readmissions to hospital can be expected to be higher than anticipated prior to the programme.

Reviewers

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